STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		A. BUILDING 00 B. WING	07/06/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRENTWOOD AT LAPORTE	2002 ANDREW AVE LA PORTE, IN46350

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R0000	This visit was for the investigation of Complaint # IN00092469. Complaint # IN00092469-Substantiated. State deficiencies related to the allegation are cited at R-52, R-86, R-90, R-246, and R-306. Survey Dates: July 5 and 6, 2011 Facility Number: 010890 Provider Number: 010890 AIM Number: N/A Survey Team: Toni Krakowski, RN Census Bed Type: Residential: 131 Total: 131 Census Payor Type: Other: 131 Total: 131 Sample: 7 These state findings are cited in accordance with 410 IAC 16.2-5. Quality review 7/11/11 by Suzanne Williams, RN	R0000	This plan of correction is not to be construed as an admission of or agreement with the findings and conclusions in the Statement of Deficiencies, or the proposed administrative penalty (with right to correct) on the community. Rather it is submitted as confirmation of our ongoing efforts to comply with all statutory and regulatory requirements. In this document, we have outlined specific actions in response to each allegation or finding. We have not presented all contrary factual or legal arguments, nor have we identified all mitigation factors.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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R0052	(v) Residents have the right to be free from: (1) sexual abuse; (2) physical abuse; (3) mental abuse; (4) corporal punishment; (5) neglect; and (6) involuntary seclusion. Based on interview and record review, the facility failed to ensure 2 residents were free from staff abuse related to the intentional increase of oxygen flow for Resident # B and the intentional striking of Resident # D who had exhibited behaviors. This deficient practice affected 2 of 2 residents reviewed for abuse in the sample of 7. Findings include: 1. During interview with the Administrator on 7/5/11 at 12:45 P.M., she indicated, when queried, that she had several State Reportables for review. A Facility Incident Reporting Form, dated 6/22/11 at 2:20 P.M., indicated CNA # 7 was walking Resident # B in the hallway when she stated to CNA # 8 that she was going to turn Resident # B's oxygen level "up all the way." CNA # 8 reported the concern to LPN #9 who went to Resident # B's room and turned her oxygen down to the appropriate setting ordered by her physician.	R0052	**Corrective Action:** 1. C.N.A # 7 was immediately put on administrative leave pending the outcome of the investigation and her employment has been terminated. The incident was reported to the Indiana State Licensing Agency. 2. C.N.A # 11 was immediately put on administrative leave pending the outcome of the investigation and her employment has been terminated. . The incident was reported to the Indiana State Licensing Agency. C.N.A # 10 was disciplined for not reporting the incident to her supervisor immediately. **How to Identify Other Residents:** 1. The Resident Care Director and/or designee conducted an audit on July 20th, 2011of the resident's in the community that wear oxygen. The audit confirmed that the resident's wearing oxygen had their oxygen at the setting ordered by their physician. 2. Executive Director and/or designee conducted staff interviews to ensure no other inappropriate behaviors have been exhibited by staff. No other residents were affected. Residents who wear oxygen will be interviewed by the Resident	08/05/2011

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	A written statement by CNA # 8, dated 6/20/11 (sic), indicated, "...(CNA # 7) was walking (Resident # B) to her room (no time of day provided). CNA # 7 said to me, 'I'll give that F..... B.... some oxygen. I'll crank it all the way up...I went to check on (Resident # B). Her oxygen was turned all the way up! At once I told (LPN # 9) about it." A written statement by LPN # 9, dated 6/21/11, indicated, "...(CNA # 8) reported to me that (CNA # 7) had an attitude with Resident (# B). (CNA # 8) also told me that (Resident # B's) O2 (oxygen) was turned way up. I went to her room and the O2 was turned up on her room concentrater (sic) to about 6 L (liters) and I had to turn it down." The Administrator on 7/5/11 at 1:10 P.M., indicated CNA # 7 was immediately put on administrative leave and then terminated after the investigation determined the facts to be as reported. All staff was in-serviced about abuse and neglect on 7/01/11. During initial tour of the facility on 7/5/11 at 11:20 A.M., while accompanied by RN # 6, she indicated Resident # B had some mild confusion, but was interviewable. Resident # B's clinical record was		Care Director and/or designee by August 5th, 2011 to ensure there were no other allegations of abuse and the family members of the residents who reside on the Memory Care Neighborhood will be interviewed by the Memory Care Director and/or designee by August 5th, 2011 as well. **Systemic Changes:** . 1. An in-service has been conducted by the Resident Care Director and/or designee on July 21st, 2011 with the nursing staff to review proper protocol for residents with oxygen. 2. An in-service has been conducted by the Executive Director and/or designee on July 21st, 2011 on Abuse Prevention, Identification, & Reporting for the staff who works at Brentwood. The ED and/or designee will randomly interview 5 residents monthly to ensure the deficient practice will not recur. **Monitoring Corrective Actions:** 1. The Resident Care Director and/or designee will conduct random audits to ensure continued compliance with appropriate oxygen settings as ordered by their physicians. Audits will be reviewed in the monthly Quality Assurance meetings. The Quality Assurance committee will determine if continued audits are necessary. 2. The staff at Brentwood will be interviewed randomly by the Executive Director to ensure they	

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	reviewed on 7/05/11 at 2:35 P.M. and indicated diagnoses of severe osteoporosis, dementia, and chronic obstructive pulmonary disease. Resident B's Physician Order Sheet, printed 6/20/11, indicated, "...Other orders: ...Plan of Treatment: ...O2 (oxygen) @ 3 LPN via N/C (nasal cannula). Encourage resident to cough and have sputum production...." A bi-annual evaluation of Resident # B titled "Ambulation and Mobility Evaluation," dated 4/4/11, indicated, "Mental status: intermittent confusion...." During an interview with Resident # B on 7/6/11 at 3:10 P.M., she indicated staff set her oxygen levels for her. She further indicated she was very happy with the care she received at the facility and had no issues with any of the facility staff. Review of Nurse's Notes lacked documentation of the above mentioned incident. 2. A Facility Incident Reporting Form, dated 6/15/11 at 2:20 P.M., indicated CNA # 10 informed (Administrator) that on June 6th, 2011 she witnessed (CNA # 11) slap (Resident # D) with an open hand across her shoulder area. (CNA # 11) was		can recite the correct policy and procedure on reporting allegations of abuse and neglect ongoing. 3. Yes, residents and/or family members will be involved in the ongoing monitoring process to ensure the deficient practice has not recurred. Residents and/or family members will be encouraged to report alleged deficient practice to ED or the management team promptly. This process will be discussed during the next Resident Council meeting on 8/18/2011, during Family Night on 8/25/2011 (MCN) and Family Night on 8/25/2011 (AL). 4.The QA Committee will determine if continued auditing is necessary after 2 consecutive quarters of full compliance. The Regional Team will randomly audit during routine visits and during the Annual Comprehensive Process Review.	

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	walking down the hallway assisting another resident down the hall when (Resident # D) caught up to them and tried to take his walker. (CNA # 11) then slapped (Resident # D) with an open hand across her shoulder area. During interview with the Administrator on 7/5/11 at 1:10 P.M., she indicated the incident happened on 6/06/11, but it was not reported to her by (CNA # 10) until 6/15/11 at 2:20 P.M. She immediately put (CNA # 11) on administrative leave and reported the incident to the State. (CNA # 11) was terminated after an investigation was completed. She further indicated (CNA # 10) was disciplined for not immediately reporting the incident to her supervisor. All staff was in-serviced on 6/22/11 regarding the protocol for reporting abuse and neglect. During initial tour of the Memory Care Unit of the facility on 7/5/11 at 12:30 P.M., LPN # 12 indicated Resident # D expired on 6/29/11 from heart failure. The clinical record of Resident # D was reviewed on 7/06/11 at 9:10 A.M. and indicated diagnosis of, but not limited to: chronic obstructive pulmonary disease (COPD), dementia with behaviors, and degenerative joint disease (DJD).			

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	Resident # D's "Resident Care Plan," indicated she was evaluated on 5/25/11 and was found to have aggressive behavior. It further explained she was verbally aggressive and resistant with care and re-direction. An "Ambulation and Mobility Evaluation," dated 6/11/11, indicated, "...Mental status: Disoriented x 3 (person, place, and time), at all times...." CNA #10 stated the following in a written statement, dated 6/15/11, "...I (CNA #10) witnessed (CNA # 11) use the open palm of her left hand to slap Resident (# D). (Resident # D) was attempting to grab another resident's walker that (CNA # 11) was assisting. (CNA # 11) slapped her for that reason. She struck her on her upper back across the shoulder area. (Resident # D) retaliated and hit (CNA # 11) back...." A facility policy titled "Abuse Prevention, Identification, & Reporting," revised 5/10/11, indicated, "Policy: To protect residents from physical, mental, fiduciary (financial), sexual and verbal abuse or neglect...Physical Abuse is the willful act of inflicting bodily injury or physical mistreatment. This includes, bur is not limited to, striking, with or without an object, slapping...Mandatory Reporting: ...Reports should be made immediately to the Executive Director, Resident Care			

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	Director or other appropriate supervisory personnel...." Review of personnel records indicated staff was properly screened prior to hire and all new staff was in-serviced on resident rights, abuse and neglect, and received dementia/alzheimer training. This state residential finding relates to complaint IN00092469.			
R0086	The licensee: (1) is responsible for compliance with all applicable laws; and (2) has full authority and responsibility for the: (A) organization; (B) management; (C) operation; and (D) control; of the licensed facility. The delegation of any authority by the licensee does not diminish the responsibilities of the licensee.			
	Based on observation, interview, and record review, the facility failed to prevent the misappropriation of residents' property for 4 residents as evidenced by the theft of narcotic medications by the QMA (qualified medication aide) and an LPN (licensed practical nurse). Indiana Code 35-43-4-2-a-2-c prohibits theft of property in a health care facility. This deficient practice affected 4 of 4 residents reviewed for theft of medications in a sample of 7.	R0086	**Corrective Action:** The four residents who had missing narcotics will have their medication replaced by the community by July 20th, 2011 if not already done so. The LPN and QMA identified during the complaint survey had been terminated by Brentwood and reported to the local police as well as the Indiana State Licensing Agency. **How to Identify Other Residents:** The Resident Care Director and/or	08/05/2011

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	Residents: # C, # D, # E, # F Findings include: 1. Resident # C's clinical record was reviewed on 7/05/11 at 3:45 P.M. and indicated diagnoses of, but not limited to: congestive heart disease, history of falls, and hernia repair. During interview with the Administrator on 7/5/11 at 12:45 P.M., she indicated the facility discovered missing narcotic medications (Residents # C, # E, and # F) and reported the incident to the State on 6/30/11. The "Facility Incident Reporting Form," (6/30/11) described the incident related to Resident # C's missing narcotics: "On the morning of June 30th, 2011 it was reported to (Administrator) by the Resident Care Director (RCD) that the bubble pack and the narc cout sheet for (Resident # C's) Lortab (narcotic pain medication) was missing from the narcotic box on the 300 hall medication room. (RCD) reported to me (Administrator) that (CNA # 5) reported to her that on 6/29/11 when she left at 2 P.M. she counted the medication with (CNA # 4) the oncoming QMA and there was 2 pills left in the package. When she		designee will conduct audits of residents that have physician orders for narcotics. Any discrepancies will be handled with the local law enforcement and corrective actions will be completed as necessary by the community. **Systemic Changes**: An in-service has been conducted by the Resident Care Director and/or designee on July 21st, 2011 for the QMA's and Nurses on the community's policy and procedure on medication administration of PRN medications, medication destruction and the proper way to complete a narcotic count between shifts. **Monitoring Corrective Actions:** The Resident Care Director and/or designee will conduct weekly audits of the MAR's and narcotic count sheets ongoing to ensure compliance. The findings will be reviewed at the monthly Quality Assurance meetings to ensure compliance. The Regional Director of Quality Services will review the weekly audits during site visits to the community as well as during the annual comprehensive process review to ensure compliance.	

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	arrived at work at 6:00 A.M. on 6/30/2011 she counted the narcotics with the QMA who had worked midnights and found that the bubble pack and the narc count sheet were missing." The report further indicated the night shift QMA (# 15) was immediately put on administrative leave and a formal investigation was started. A Physician's Order, dated 2/14/11, indicated, "Lortab (narcotic pain medication) 7.5/500 mg. (milligram), two tablets orally every 4 hours as needed." Review of Resident # C's Medication Administration Record (MAR) indicated she had received PRN medications from QMA (qualified medication aide) # 4 as follows: Vicodin (narcotic pain medication) 7.5/750 mg. one tablet: 1/10/11 at 9:00 P.M., 1/11/11 at 4:00 P.M. and 9:00 P.M., 1/12/11 at 3:30 P.M. and 7:30 P.M.; Tylenol ES (extra strength) 1000 mg.: 1/01/11 at 8:00 P.M., 1/02/11 at 8:00 P.M., 1/05/11 at 8:00 P.M., 1/06/11 at 8:00 P.M., 1/07/11 at 4:00 P.M. and 10:00 P.M.; Lortab 7.5/500 mg., two tablets: 5/12/11 at 3:00 P.M. and 9:00 P.M., 5/16/11 at 3:00 P.M. and 5:00 P.M., 5/17/11 at 3:00 P.M. and 5:00 P.M., 5/18/11 at 3:00 P.M. and 5:00 P.M., 5/20/11 at 3:00 P.M. and 9:00 P.M., 5/21/11 at 3:00 P.M. and 9:00 P.M., 5/22/11 at 3:00 P.M. and 9:00 P.M.,			

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	5/23/11 at 3:00 P.M. and 9:00 P.M., 5/25/11 at 3:00 P.M. and 9:00 P.M., 5/26/11 at 3:00 P.M. and 9:00 P.M., 5/27/11 at 3:00 P.M. and 9:00 P.M., 5/30/11 at 3:00 P.M. and 9:00 P.M., 5/31/11 at 3:00 P.M. and 9:00 P.M., 6/07/11 at 3:00 P.M. and 9:00 P.M., 6/08/11 at 4:00 P.M. and 9:00 P.M., 6/09/11 at 3:00 P.M. and 9:00 P.M., 6/10/11 at 3:00 P.M. and 9:00 P.M., 6/13/11 at 3:00 P.M. and 9:00 P.M., 6/14/11 at 3:00 P.M. and 9:00 P.M., 6/15/11 at 3:00 P.M. and 9:00 P.M., 6/17/11 at 3:00 P.M. and 9:00 P.M., 6/18/11 at 3:00 P.M. and 9:00 P.M., 6/19/11 at 3:00 P.M. and 9:00 P.M., 6/21/11 at 5:00 P.M. and 9:00 P.M., 6/22/11 at 3:00 P.M. and 9:00 P.M., 6/23/11 at 4:30 P.M. and 9:30 P.M., 6/24/11 at 3:00 P.M. and 9:00 P.M., 6/27/11 at 3:00 P.M. and 9:00 P.M., 6/28/11 at 3:00 P.M. and 9:00 P.M., 6/29/11 at 3:00 P.M. and 9:00 P.M., 6/30/11 at 3:00 P.M. and 9:00 P.M., 7/02/11 at 3:00 P.M. and 9:00 P.M., 7/03/11 at 3:00 P.M. and 9:00 P.M., and 7/04/11 at 3:00 P.M. and 9:00 P.M. This reflects a total of 79 times. During interview with alert and oriented (identified as such by RN # 6 during initial tour on 7/5/11 at 11:20 A. M) Resident # C on 7/6/11 at 4:30 P.M., she indicated she gets something for pain two			

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	times a day. "I receive the narcotic pain medication early in the morning, usually between three and five A.M., because my back hurts from lying in bed and I get two Tylenol every evening around 8 or 9 o'clock." Resident # C described her Tylenol as a "red and blue capsule." She further indicated that her pain medication was PRN and she had to ask the nurse for it if she needed it. Resident # C's Tylenol was observed in the medication cart immediately following the interview and the Tylenol capsules were observed to be half red and half blue. QMA # 14 assisted with the observation of the medication cart and identified the Tylenol as belonging to Resident # C. The label on the bottle was marked with Resident # C's name. During interview with QMA # 14 at 4:50 P.M., she indicated she was on duty the evenings of July 1st and 4th and Resident # C did not complain of pain nor request anything for pain. Review of the MAR (Medication Administration Record), Nurse's Notes, and the Controlled Substance Shift Count Record lacked documentation to indicate QMA # 4 had a licensed nurse authorize administration of the PRN narcotic medications prior to administration, as required by State law and facility policy.			

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	2. The following was reported to State on 7/01/11: "Facility Incident Reporting Form: On the morning of June 30th, 2011 it was reported to (Administrator) by the Resident Care Director (RCD) that the bubble pack and the narc count sheet for (Resident # E's) Hydrocodone (narcotic pain medication) was missing from the narcotic box on the 300 hall medication room. (RCD) told me that (CNA # 5) reported to her that on 6/15/11 when she left at 2 P.M. she counted the medication with (CNA # 4) the oncoming QMA and there was 10 pills left in the package. When she arrived at work at 6:00 A.M. on 6/16/11 she counted the narcotics with the QMA who had worked midnights and everything checked ok until she went to pull (Resident # E's) noon dose of the medication and found that the bubble pack and the narc count sheet were missing. The report further indicated the night shift QMA (# 15) was immediately put on administrative leave and a formal investigation was started. The clinical record of Resident # E was reviewed on 7/06/11 at 10:00 A.M. and indicated diagnoses of, but not limited to: degenerative joint disease in multiple joints, hypertension, and osteoarthritis. Physician's Orders, dated 8/17/09,			

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	indicated, (a.) "Hydrocodone-APAP (narcotic pain medication) 10/325 mg. (milligram). Give 1 tablet orally every 4 hours as needed at night. (b.) Hydrocodone-APAP 10/325 mg. Give 1 tablet orally 2 times a day (scheduled times). (c.) Morphine Sulf (sulfate) (narcotic pain medication) 30 mg. tablet. Give 1 tablet orally 2 times a day (scheduled times). Review of Resident # E's Medication Administration Record (MAR) indicated she had received PRN medications from a QMA # 4 as follows: Hydrocodone-APAP (a narcotic pain medication) 10/325 mg., one tablet: 5/03/11 at 8:00 P.M., 5/12/11 at 8:00 P.M., 5/17/11 at 8:00 P.M., 5/20/11 at 8:00 P.M., 5/21/11 at 8:00 P.M., 5/25/11 at 8:00 P.M., 5/27/11 at 8:00 P.M., 5/30/11 at 8:00 P.M., 6/18/11 at 8:00 P.M., 6/21/11 at 8:00 P.M., 6/30/11 at 8:00 P.M. and 7/02/11 at 8:00 P.M. This reflects a total of 12 times. Review of the MAR (Medication Administration Record), Nurse's Notes, and the Controlled Substance Shift Count Record lacked documentation to indicate QMA # 4 had a licensed nurse authorize administration of the PRN narcotic medications prior to administration, as required by State law and facility policy.			

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		A. BUILDING 00 B. WING	07/06/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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	3. Review of a "Facility Incident Reporting Form," incident date of 7/1/11, indicated the following: On July 3,2011 it was reported to (Administrator) by (LPN # 16) that on Thursday, June 30th, (Resident # F) had taken her Norco (narcotic pain medication) in the evening and when she went to take it on Friday, July 1st, the bottle was gone from her apartment. A complete search was completed of her apartment and the medication could not be found. Resident # F's clinical record was reviewed on 7/06/11 at 8:15 A.M. and indicated diagnoses of, but not limited to, congestive heart failure, hypertension, and a fractured shoulder. A Physician's Order, dated 6/24/11, indicated, "Norco 5/325 mg. 1 tab (tablet) PO (orally) Q (every) 6 hrs. (hours)." The order was for 30 tablets. During interview with the Administrator on 7/06/11 at 9:10 A.M., she indicated a thorough search of the apartment did not reveal the missing narcotics. "Staff called the physician and received a new order for the pain medication so the resident would not have pain from her fractured shoulder." She further indicated Resident # F was in the hospital to have the shoulder surgically repaired.			

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	4. The clinical record of Resident # D was reviewed on 7/06/11 at 9:10 A.M. and indicated diagnosis of, but not limited to: chronic obstructive pulmonary disease (COPD), dementia with behaviors, and degenerative joint disease (DJD). A Physician's Order, dated 5/25/11, indicated, "Hydrocodone-APAP (a narcotic pain medication) 5-325 MG (milligrams). Give 1 tablet orally 3 times a day as needed for pain"...Lorazepam (anti-anxiety medication) 0.5 mg. tablet. give 1 tablet orally 2 times a day as needed for anxiety. Both of these medications were discontinued on 6/29/11 when Resident # D became a Hospice patient and was placed on "comfort measures only." A new Physician's Order took effect on 6/29/11 as follows: "Lorazepam Intensol 2mg/ml (milliliter) (give) 0.125 ml. Q (every) 4 hours as needed for agitation/discomfort...Fentanyl Transdermal (topical narcotic pain medication) 25 mcg (micrograms)/hr (hour). 1 patch Q 72 hours." Review of the Medication Destruction Record, dated 6/29/11, indicated, "Fentanyl 25 mcg. ...quantity disposed: 4 patches cut-up...." The record indicated LPN #2 signed she destroyed the Fentanyl patches and LPN #3 signed she witnessed			

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	the destruction. However, further review of the Medication Destruction Record indicated LPN # 2 recorded 19 tablets of Lorazepam 0.5 mg were destroyed and 55 tablets of Hydrocodone 5/325 mg. and 30 ml. of liquid Lorazepam 2mg/ml. were returned to the local pharmacy. The Medication Destruction Record lacked a signature of a witness to verify the Lorazepam 0.5 mg. tablets were destroyed or the Hydrocodone 5/325 mg. tablets and the 30 ml. of Lorazepam 2mg/ml. liquid were returned to the pharmacy. During interview with QMA # 5 on 7/5/11 at 1:45 P.M., she indicated the evening shift QMA leaves before the night shift QMA comes on duty. When queried if the narcotic count between the evening shift and night shift was correct, QMA # 5 responded, "I don't know because the narc sheet was missing. They didn't always have two people count on that shift because as I said, second shift goes home prior to the third shift arrival." She admitted that staff hasn't always counted the narcotics with a second staff person. The Administrator indicated in an interview on 7/6/11 at 9:15 A.M., she would call the pharmacy to verify the narcotics had been returned to them. In an interview at 9:45 A.M. on 7/6/11, the Administrator indicated the pharmacy			

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	reported to her that they had received the unopened, 30 ml. bottle of Lorazepam 2mg/ml. (liquid), but did not receive any of the 55 Hydrocodone 5/325 mg. tablets from the facility. The Administrator indicated she would immediately report the unaccounted for Hydrocodone 5/325 mg. (55 tablets) and the Lorazepam 0.5 mg. (19 tablets) to the police for investigation. LPN #2 was not interviewed in order to avoid interference with the police investigation. A facility policy titled "Medication-Professional Practice Guidelines," revised 9/29/10, indicated, "Policy: Medications are to be administered/assisted within current professional practice guidelines designated by the state in which the professional practices, labeled precautions and literature devoted to medication administration...Controlled Substances/Medications: In order to guard against the theft and/or unlawful diversion of controlled substances, community shall follow procedures as outlined...Documentation: Complete Controlled Substance Shift Count record at each shift change, a minimum of three times per day...Destruction: ...Controlled medications may be returned to the pharmacy or destroyed at the community using the medication destruction			

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	procedures and documentation...." This state residential finding relates to complaint IN00092469.			

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R0090	(g) The administrator is responsible for the overall management of the facility. The responsibilities of the administrator shall include, but are not limited to, the following: (1) Informing the division within twenty-four (24) hours of becoming aware of an unusual occurrence that directly threatens the welfare, safety, or health of a resident. Notice of unusual occurrence may be made by telephone, followed by a written report, or by a written report only that is faxed or sent by electronic mail to the division within the twenty-four (24) hour time period. Unusual occurrences include, but are not limited to: (A) epidemic outbreaks; (B)poisonings; (C) fires; or (D) major accidents. If the division cannot be reached, a call shall be made to the emergency telephone number published by the division. (2) Promptly arranging for or assisting with the provision of medical, dental, podiatry, or nursing care or other health care services as requested by the resident or resident's legal representative. (3) Obtaining director approval prior to the admission of an individual under eighteen (18) years of age to an adult facility. (4) Ensuring the facility maintains, on the premises, an accurate record of actual time worked that indicates the: (A) employee's full name; and (B) dates and hours worked during the past twelve (12) months. (5) Posting the results of the most recent annual survey of the facility conducted by state surveyors, any plan of correction in effect with respect to the facility, and any subsequent surveys. The results must be available for examination in the facility in a place readily accessible to residents and a			

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	notice posted of their availability. (6) Maintaining reports of surveys conducted by the division in each facility for a period of two (2) years and making the reports available for inspection to any member of the public upon request Based on interview and record review, the facility failed to ensure an incident of abuse was reported to the State in the required time frame for 1 of 2 residents reviewed for abuse in the sample of 7. (Resident # D) Findings include: A Facility Incident Reporting Form, dated 6/15/11 at 2:20 P.M., indicated CNA # 10 informed (Administrator) that on June 6th, 2011 she witnessed (CNA # 11) slap (Resident # D) with an open hand across her shoulder area. (CNA # 11) was walking down the hallway assisting another resident down the hall when (Resident # D) caught up to them and tried to take his walker. (CNA # 11) then slapped (Resident # D) with an open hand across her shoulder area. During interview with the Administrator on 7/5/11 at 1:10 P.M., she indicated the incident happened on 6/06/11, but it was not reported to her (by CNA # 10) until 6/15/11 at 2:20 P.M. She immediately put (CNA # 11) on administrative leave and reported the incident to the State. (CNA #	R0090	**Corrective Action:** The employee's identified during the survey have been disciplined for not following the community's policy and procedure on reporting allegations of resident abuse. **How to Identify Other Residents:** Executive Director and/or designee conducted staff interviews to ensure no other inappropriate behaviors have been exhibited by staff. No other residents were affected. **Systemic Changes**: An in-service has been conducted by the Executive Director and/or designee on July 21st, 2011 on Abuse Prevention, Identification, & Reporting for the staff who works at Brentwood. **Monitoring Corrective Actions:** The staff at Brentwood will be interviewed randomly by the Executive Director to ensure they can recite the correct policy and procedure on reporting allegations of abuse and neglect ongoing.	08/05/2011

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	11) was terminated after an investigation was completed. She further indicated (CNA # 10) was disciplined for not immediately reporting the incident to her supervisor. All staff was in-serviced on 6/22/11 regarding the protocol for reporting abuse and neglect. A facility policy titled "Abuse Prevention, Identification, & Reporting," revised 5/10/11, indicated, "Policy: To protect residents from physical, mental, fiduciary (financial), sexual and verbal abuse or neglect...Physical Abuse is the willful act of inflicting bodily injury or physical mistreatment. This includes, bur is not limited to, striking, with or without an object, slapping...Mandatory Reporting: ...Reports should be made immediately to the Executive Director, Resident Care Director or other appropriate supervisory personnel...." This state residential finding relates to complaint IN00092469.			
R0246	(6) PRN medications may be administered by a qualified medication aide (QMA) only upon authorization by a licensed nurse or physician. The QMA must receive appropriate authorization for each administration of a PRN medication. All contacts with a nurse or physician not on the premises for authorization to administer PRNs shall be documented in the nursing notes indicating the time and date of the contact.			

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	Based on interview and record review, the facility failed to ensure PRN (as needed) medications administered by the QMA (qualified medication aide) were appropriately authorized by a licensed nurse prior to administration for 4 of 7 residents reviewed with PRN medications in a sample of 7. Resident: # C, # E, # G, and # H. Findings include: 1. Resident # C's clinical record was reviewed on 7/05/11 at 3:45 P.M. and indicated diagnoses of, but not limited to: congestive heart disease, history of falls, and hernia repair. Review of Resident # C's Medication Administration Record (MAR) indicated she had received PRN medications from a QMA (qualified medication aide) without the authorization of a licensed nurse. Vicodin (narcotic pain medication) 7.5/750 mg. (milligram) one tablet administered by QMA # 4: 1/10/11 at 9:00 P.M., 1/11/11 at 4:00 P.M. and 9:00 P.M., 1/12/11 at 3:30 P.M. and 7:30 P.M.; Tylenol ES (extra strength) 1000 mg. administered by QMA # 4: 1/01/11 at 8:00 P.M., 1/02/11 at 8:00 P.M., 1/05/11 at 8:00 P.M., 1/06/11 at 8:00 P.M., 1/07/11 at 4:00 P.M. and 10:00 P.M.; Lortab	R0246	**Corrective Action:** QMA's that are employed at Brentwood have been re-educated on the proper way PRN medication should be administered. **How to Identify Other Residents:** The Resident Care Director and/or designee will conduct audits of residents that have physician orders for prn medications. No residents were affected. **Systemic Changes**: An in-service has been conducted by the Resident Care Director and/or designee on July 21st, 2011 for the QMA's and Nurses on the community's policy and procedure on administration of PRN medications. **Monitoring Corrective Actions:** The Resident Care Director and/or designee will conduct weekly audits of the MAR's ongoing to ensure compliance. The Regional Director of Quality Services will review the weekly audits during site visits to the community as well as during the annual comprehensive process review to ensure compliance.	08/05/2011

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	(narcotic pain medication) 7.5/500 mg., two tablets, administered by QMA # 4: 5/12/11 at 3:00 P.M. and 9:00 P.M., 5/16/11 at 3:00 P.M. and 5:00 P.M., 5/17/11 at 3:00 P.M. and 5:00 P.M., 5/18/11 at 3:00 P.M. and 5:00 P.M., 5/20/11 at 3:00 P.M. and 9:00 P.M., 5/21/11 at 3:00 P.M. and 9:00 P.M., 5/22/11 at 3:00 P.M. and 9:00 P.M., 5/23/11 at 3:00 P.M. and 9:00 P.M., 5/25/11 at 3:00 P.M. and 9:00 P.M., 5/26/11 at 3:00 P.M. and 9:00 P.M., 5/27/11 at 3:00 P.M. and 9:00 P.M., 5/30/11 at 3:00 P.M. and 9:00 P.M., 5/31/11 at 3:00 P.M. and 9:00 P.M., 6/07/11 at 3:00 P.M. and 9:00 P.M., 6/08/11 at 4:00 P.M. and 9:00 P.M., 6/09/11 at 3:00 P.M. and 9:00 P.M., 6/10/11 at 3:00 P.M. and 9:00 P.M., 6/13/11 at 3:00 P.M. and 9:00 P.M., 6/14/11 at 3:00 P.M. and 9:00 P.M., 6/15/11 at 3:00 P.M. and 9:00 P.M., 6/17/11 at 3:00 P.M. and 9:00 P.M., 6/18/11 at 3:00 P.M. and 9:00 P.M., 6/19/11 at 3:00 P.M. and 9:00 P.M., 6/21/11 at 5:00 P.M. and 9:00 P.M., 6/22/11 at 3:00 P.M. and 9:00 P.M., 6/23/11 at 4:30 P.M. and 9:30 P.M., 6/24/11 at 3:00 P.M. and 9:00 P.M., 6/27/11 at 3:00 P.M. and 9:00 P.M., 6/28/11 at 3:00 P.M. and 9:00 P.M., 6/29/11 at 3:00 P.M. and 9:00 P.M., 6/30/11 at 3:00 P.M. and 9:00 P.M., 7/02/11 at 3:00 P.M. and 9:00 P.M.,			

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	7/03/11 at 3:00 P.M. and 9:00 P.M., and 7/04/11 at 3:00 P.M. and 9:00 P.M. This reflects a total of 79 times without prior authorization. Review of Nurse's Notes and the Controlled Substance Shift Count Record also lacked documentation to indicate QMA # 4 had a licensed nurse authorize administration of the PRN medications. 2. The clinical record of Resident # E was reviewed on 7/06/11 at 10:00 A.M. and indicated diagnoses of, but not limited to: degenerative joint disease in multiple joints, hypertension, and osteoarthritis. Review of Resident # E's Medication Administration Record (MAR) indicated she had received PRN medications from a QMA without the authorization of a licensed nurse. Hydrocodone-APAP (a narcotic pain medication) 10/325 mg., one tablet, administered by QMA # 4: 5/03/11 at 8:00 P.M., 5/12/11 at 8:00 P.M., 5/17/11 at 8:00 P.M., 5/20/11 at 8:00 P.M., 5/21/11 at 8:00 P.M., 5/25/11 at 8:00 P.M., 5/27/11 at 8:00 P.M., 5/30/11 at 8:00 P.M., 6/18/11 at 8:00 P.M., 6/21/11 at 8:00 P.M., 6/30/11 at 8:00 P.M. and 7/02/11 at 8:00 P.M. This reflects a total of 12 times without prior authorization. Review of Nurse's Notes and the Controlled Substance Shift Count			

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	Record also lacked documentation to indicate QMA # 4 had a licensed nurse authorize administration of the PRN medications. 3. Resident G's clinical record was reviewed on 7/06/11 at 4:45 P.M. and indicated diagnoses of, but not limited to: congestive heart failure, chronic obstructive pulmonary disease, and anxiety. Review of Resident # G's Medication Administration Record (MAR) indicated she had received PRN medications from a QMA without the authorization of a licensed nurse. Hydrocodone-APAP (a narcotic pain medication) 10/325 mg., one tablet, administered by QMA # 4: 4/01/11 at 8:00 P.M., 4/04/11 at 8:00 P.M., 4/05/11 at 8:00 P.M., 4/06/11 at 8:00 P.M., 4/07/11 at 8:00 P.M., 4/09/11 at 8:00 A.M. and 8:00 P.M., 4/10/11 at 8:00 A.M. and 8:00 P.M., 4/11/11 at 8:00 P.M., 4/12/11 at 8:00 P.M., 4/14/11 at 7:00 P.M., 4/18/11 at 2:45 A.M., 4/19/11 at 6:00 P.M., 4/20/11 at 7:00 P.M., 4/22/11 at 8:00 P.M., 4/23/11 at 6:00 P.M., 4/24/11 at 7:00 P.M., 4/25/11 at 9:00 P.M., 5/12/11 at 9:00 P.M., 5/16/11 at 5:00 P.M., 5/16/11 at 5:00 P.M., 5/17/11 at 5:00 P.M., 5/18/11 at 5:00 P.M., 5/20/11 at 5:00 P.M., 5/21/11 at 5:00 P.M., 5/23/11 at 5:00 P.M., 5/25/11 at 5:00 P.M., 5/26/11 at 5:00 P.M., 5/27/11			

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	at 5:00 P.M., 5/30/11 at 6:00 P.M., 5/31/11 at 7:00 P.M., 6/01/11 at 5:00 P.M., 6/02/11 at 5:00 P.M., 6/04/11 at 9:00 P.M., 6/05/11 at 5:00 P.M., 6/08/11 at 9:00 P.M., 6/09/11 at 5:00 P.M., 6/10/11 at 5:00 P.M., 6/13/11 at 5:00 P.M., 6/15/11 at 5:00 P.M., 6/27/11 at 5:00 P.M., 6/28/11 at 5:00 P.M., and 6/30/11 at 5:00 P.M. This reflects a total of 44 times without prior authorization. Review of Nurse's Notes and the Controlled Substance Shift Count Record also lacked documentation to indicate QMA # 4 had a licensed nurse authorize administration of the PRN medications. 4. Resident H's clinical record was reviewed on 7/06/11 at 5:15 P.M. and indicated diagnoses of, but not limited to: anemia, congestive heart failure, and osteoporosis. Review of Resident # H's Medication Administration Record (MAR) indicated she had received PRN medications from a QMA without the authorization of a licensed nurse. Hydrocodone-APAP (a narcotic pain medication) 5/500 mg., one tablet, administered by QMA # 4: 4/04/11 at 4:30 P.M., 4/06/11 at 4:30 P.M., 4/07/11 at 4:30 P.M., 4/09/11 at 10:00 A.M. and 5:00 P.M., 4/12/11 at 5:00 P.M., 4/14/11 at 5:00 P.M., 4/15/11 at 8:00 P.M., 5/04/11 at 5:00 P.M., 5/07/11 at 3:00 P.M. and 9:00 P.M., 5/18/11 at 3:00 P.M. and			

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		A. BUILDING 00 B. WING	07/06/2011

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	9:00 P.M., 5/20/11 at 2:30 P.M. and 9:00 P.M., 5/21/11 at 3:00 P.M. and 9:00 P.M., 5/26/11 at 3:00 P.M. and 9:00 P.M., 5/27/11 at 3:00 P.M. and 9:00 P.M., 5/30/11 at 3:00 P.M. and 9:00 P.M., 6/01/11 at 3:00 P.M. and 9:00 P.M., 6/02/11 at 3:00 P.M. and 9:00 P.M. and 6/05/11 at 3:00 P.M. and 9:00 P.M. This reflects a total of 29 times without prior authorization. Review of Nurse's Notes and the Controlled Substance Shift Count Record also lacked documentation to indicate QMA # 4 had a licensed nurse authorize administration of the PRN medications. During interview with the Administrator on 7/05/11 at 4:50 P.M., she indicated that all nursing staff had been in-serviced in March about medication administration and the need for a nurse's signature for authorization of a PRN medication. "They were told. They know better." QMA # 4 was unavailable for interview. A facility policy titled "Medication-Professional Practice Guidelines," revised 9/29/10, indicated, "Policy: Medications are to be administered/assisted within current professional practice guidelines designated by the state in which the professional practices, labeled precautions			

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	and literature devoted to medication administration...Medication Administration/Assistance: Licensed nurses may delegate administration only if the state's practice guidelines permit this practice...Documentation that the medication has or has not been administered/assisted will be entered on the Medication Administration/Observation Record...." This state residential finding relates to complaint IN00092469.			
R0306	(g) Medications administered by the facility shall be disposed in compliance with appropriate federal, state, and local laws, and disposition of any released, returned, or destroyed medication shall be documented in the resident ' s clinical record and shall include the following information: (1) The name of the resident. (2) The name and strength of the drug. (3) The prescription number. (4) The reason for disposal. (5) The amount disposed of. (6) The method of disposition. (7) The date of the disposal. (8) The signature of the person conducting the disposal of the drug. (9) The signature of a witness, if any, to the disposal of the drug. Based on interview and record review, the facility failed to ensure narcotic medication was disposed of according to State law related to the lack of a licensed nurse to witness the disposition of the	R0306	**Corrective Action:** LPN # 2 has received disciplinary action and no longer works at Brentwood. **How to Identify Other Residents:** No other residents were affected.	08/05/2011

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	medication and failure to document it in the resident's clinical record for 1 of 6 residents reviewed with narcotic medications in a sample of 7. Resident: # D Findings include: The clinical record of Resident # D was reviewed on 7/06/11 at 9:10 A.M. and indicated diagnosis of, but not limited to: chronic obstructive pulmonary disease (COPD), dementia with behaviors, and degenerative joint disease (DJD). A Physician's Order, dated 5/25/11, indicated, "Hydrocodone-APAP (a narcotic pain medication) 5-325 MG (milligrams). Give 1 tablet orally 3 times a day as needed for pain"...Lorazepam (anti-anxiety medication) 0.5 mg. tablet. give 1 tablet orally 2 times a day as needed for anxiety. Both of these medications were discontinued on 6/29/11 when Resident # D became a Hospice patient and was placed on "comfort measures only." A new Physician's Order took effect on 6/29/11 as follows: "Lorazepam Intensol 2mg/ml (milliliter) (give) 0.125 ml. Q (every) 4 hours as needed for agitation/discomfort...Fentanyl Transdermal (topical narcotic pain medication) 25 mcg (micrograms)/hr		**Systemic Changes**: An in-service has been conducted by the Resident Care Director and/or designee on July 21st, 2011 for the QMA's and Nurses on the community's policy and procedure on medication destruction . **Monitoring Corrective Action:** Random audits of the resident medication destruction records will be completed by the Resident Care Director and/or designee monthly and the findings will be reported to the Quality Assurance Committee to ensure ongoing compliance.	

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	(hour). 1 patch Q 72 hours." A Nurse's Note, dated 6/29/11 at 9:40 P.M., indicated the Resident # D had expired. "Called to room per family. No heart beat detected and no respirations (sic)...." Review of the Medication Destruction Record, dated 6/29/11, indicated, "Fentanyl 25 mcg. ...quantity disposed: 4 patches cut-up...." The record indicated LPN #2 signed she destroyed the Fentanyl patches and LPN #3 signed she witnessed the destruction. However, further review of the Medication Destruction Record indicated LPN # 2 recorded 19 tablets of Lorazepam 0.5 mg were destroyed and 55 tablets of Hydrocodone 5/325 mg. and 30 ml. of liquid Lorazepam 2mg/ml. were returned to the local pharmacy. The Medication Destruction Record lacked a signature of a witness to verify the Lorazepam 0.5 mg. tablets were destroyed or the Hydrocodone 5/325 mg. tablets and the 30 ml. of Lorazepam 2mg/ml. liquid were returned to the pharmacy. During an interview with the Administrator on 7/6/11 at 9:15 A.M., she indicated she would call the pharmacy to verify the narcotics had been returned to them. In an interview at 9:45 A.M. on 7/6/11, the Administrator indicated the			

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	pharmacy reported to her that they had received the unopened, 30 ml. bottle of Lorazepam 2mg/ml. (liquid), but did not receive any of the 55 Hydrocodone 5/325 mg. tablets from the facility. The administrator indicated she would immediately report the unaccounted for Hydrocodone 5/325 mg. (55 tablets) and the Lorazepam 0.5 mg. (19 tablets) to the police for investigation. LPN #2 was not interviewed in order to avoid interference with the police investigation. A facility policy titled "Medication-Professional Practice Guidelines," revised 9/29/10, indicated, "Policy: Medications are to be administered/assisted within current professional practice guidelines designated by the state in which the professional practices, labeled precautions and literature devoted to medication administration...Controlled Substances/Medications: In order to guard against the theft and/or unlawful diversion of controlled substances, community shall follow procedures as outlined...Destruction: ...Controlled medications may be returned to the pharmacy or destroyed at the community using the medication destruction procedures and documentation...." This state residential finding relates to			

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	complaint IN00092469.			